BOSTIC
VETERINARY HOSPITAL

Client Information

Home Phone _____

Owner's Name _____ Email _____

Home Address _____ City _____ Zip _____

Employer's Name _____ Work Phone _____

Spouse's Name _____ Cell Phone _____

Spouse's Employer _____ Work Phone _____

Referred By _____

REQUEST FOR SERVICES - AUTHORIZATION FOR EXAMINATION AND MEDICAL TREATMENT

I am the owner or agent for the owner of the animal(s) described below and have authority to execute this document.

I request that the Bostic Veterinary Hospital, its veterinarians, agents and employees perform the services which are necessary to the examination and medical treatment of the animals described in this file.

I authorize the veterinarians on duty (and assistants they may designate) to examine the animal(s) and to administer medical or emergency surgical treatment which is considered therapeutically and/or diagnostically necessary on the basis of the findings during the course of examinations. Therefore, I hereby consent to and authorize the performance of such procedure(s) as are necessary and desirable in the exercise of the veterinarian's professional judgments.

I further understand that any animal found to be infected with other external (fleas or ticks) or internal (worms) parasites will be treated for same at my expense.

I understand that the treatment of the patient will be conducted with due care and in accordance with the prevailing standards of competency in veterinary medicine. I certify, that no guarantee or assurance has been made as the results that may be obtained through the course of treatment undertaken by the Bostic Veterinary Hospital, its veterinarians, agents or employees.

I also consent to the release of medical information.

FINANCIAL RESPONSIBILITY

I ASSUME FINANCIAL RESPONSIBILITY FOR ALL CHARGES TO THE PATIENT FOR SERVICES RENDERED AND UNDERSTAND THAT FULL PAYMENT IS REQUIRED UPON DISCHARGE. ANY CHARGES NOT PAID IN 30 DAYS WILL HAVE FINANCE CHARGES OF 1 1/2% PER MONTH (18% ANNUAL) ADDED. ANY ACCOUNT REQUIRING LEGAL ACTION WILL HAVE LEGAL FEES OF 33 1/3% AND ALL COURT COSTS ADDED TO THE ACCOUNT. AN ESTIMATE OF CHARGES IS AVAILABLE WITH A REASONABLE TIME AT MY REQUEST.

X Signature of Owner or Agent _____ Date _____

Animal Information

Name _____ Sex M F S (spayed) N (neutered) Weight _____

Canine (06)____ Feline (10)____ Other _____ Breed _____ Color/Markings _____ D.O.B. _____

Place of Last Immunization _____ Phone # _____

Date of Last Immunization:

Canine - DHPP _____ Heartworm Test _____ Lyme _____ Bord _____ Rabies _____

Feline - FDRCV _____ Leukemia _____ Leuk Test _____ Rabies _____

FOR HOSPITAL USE ONLY

	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE
DHPP									
BORD									
LYME									
LEPTO									
RV									
RV #									
HWO									
FECAL									
RESULTS									
FDRCV									
FELV									
RV									
RV #									
LEUK CK									
FECAL									
RESULTS									